Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4881BPR	A. BUILDING _____ B. WING _____	05/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AKAMAI SENIOR OPTIONS	4024 PERFECT LURE STREET LAS VEGAS, NV 89129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 000	Initial Comment The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a resurvey conducted in your facility on 05/10/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. One sample client file was reviewed at the time of the survey. The following deficiency was identified:	K 000		
K 022 SS=C	NAC 449.27829 Responsibilities of Referral Agency 2. A referral agency shall not: (a) Accept any fee, inducement or incentive, for any reason, from a residential facility for groups or from any person or entity associated with a residential facility for groups. This Regulation is not met as evidenced by: Based upon interview and document review on 5/12/10, the failed to ensure it was accepting fees for services from residential facilities for groups. Severity: 1 Scope :3	K 022		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE